METRO HOMES, INC.

6856 Eastern Avenue, NW., Suite 214
Washington, D.C. 20012
TEL: (202) 829-1707
Fax: (202) 829-0616
Email: NGatehomes@aol.com

February 16, 2007

Pat VanBuren
Department of Health and Human Services
Intermediate Care Facilities Division
825 North Capitol Street NE 2nd Floor
Washington, DC 20002

Dear Ms. VanBuren,

Attached you will find our plan of corrections for 4424 20th Street NE Washington, DC (Claire House). If any other additional information is needed please contact me at the above mentioned number.

Sincerely,

Susan J. Sloan RN, BSN, MA

Susan Sloan
Vice President of Operations

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health

Health Regulation
& Licensing Administration

SENT via FACSIMILE and US MAIL

February 8, 2007

Maxwell Asenso
Executive Director
Metro Homes, Inc.
6856 Eastern Avenue, NW, Suite 214
Washington, DC 20001

RE: 4424 20th Street, NE

Dear Mr. Asenso:

You will find enclosed a Statement of Deficiencies reports for federal certification and licensure. The reports enumerate deficiencies found as a result of the survey conducted on January 24, 2007. You are required to respond to each deficiency. Although a reasonable period of time may be allowed for actual correction of these deficiencies, it is imperative that your plan be signed with a specific date for anticipated completion and returned to this office prior to **February 20, 2007**. Since these reports are subject to public disclosure, it is necessary that the responses be indicated on the original forms (and not on an attachment, except if submitting a copy of a policy change). NOTE: "Corrected" is not an accepted reply. The plan MUST also include the following.

- **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**

- **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;**

- **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and**

- **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be implemented.**

PLEASE NOTE: Plans of Correction not adhering to the above requirements will not be considered acceptable. Also, failure to submit acceptable plans, within the specified time frame, MAY result in the loss of Medicaid reimbursement.

If you have any questions or concerns regarding the above, please contact Ms. Sheila Pannell, Supervisory Health Service Program Specialist, Intermediate Care Facilities Division on (202) 442-5888.

Sincerely,

Patricia W. VanBuren
Program Manager

Enclosures

cc: Medical Assistance Administration
Department on Disability Services

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G162	A. BUILDING _____ B. WING _____	01/25/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES	4424 20TH STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A recertification survey was conducted from 1/23/2007 through 1/25/2007. The survey was conducted using the fundamental survey process. A random sample of two clients was selected from a resident population of four clients with various disabilities. The findings of the survey were based on observations, interviews, with clients and staff in the home and at two day programs, as well as a review of client and administrative records, including incident reports.	W 000		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review the facility ' s Qualified Mental Retardation Professional (QMRP) failed to ensure the coordination of services to manage a client ' s maladaptive behavior for two of three sampled clients; failed to ensure the assessment of the door alarms; failed to ensure the revision of client programs; failed to ensure the implementation of a client ' s self medication program; and failed to ensure client ' s meals were served in the form and consistency as required. The findings include: 1. Observation of Client #3 at her Day Program on 1/24/2007 revealed that she and a small group of her peers were sitting in a small classroom located at the rear of the facility. Staff interview revealed that Client #3 takes part with this group	W 159	W159 -1 Effective March 2, 2007, Metro Homes, Inc. has extended the services of the residential psychologist to the day Program and all BSPs will be evaluated This client's Behavior Support Plans will be reevaluated by this psychologist and both plans will be merged for consistency in the implementation methodologies.	3/15/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Zuwena Sloan VP — 2/14/07

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G162	A. BUILDING _____ B. WING _____	01/25/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES	4424 20TH STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159	Continued From page 1 due to her age and maladaptive behaviors; screaming, and hitting. Record review on 1/24/2007 revealed that Client #3 had two separate Behavior Support Plans. The first plan reviewed was created on 1/15/2007 and was identified as a plan to be implemented at her home and it targeted the following maladaptive behaviors: physical aggression, property destruction, and hollering. The second plan dated 1/16/2007 was created for her Day Program and was expected to be implemented at that location only. The targeted maladaptive behaviors for that second plan are physical aggression, and agitation. Both plans provided different methodologies to address the targeted behaviors and also provided different definitions for the targeted behaviors as well. The facility ' s Qualified Mental Retardation Professional (QMRP) indicated that she did not know if the Psychologist at the Day Program had met and/or reviewed notes with the Psychologist for the home when they were developing their respective behavior management plans. There was no evidence that the facility ' s QMRP ensured the creation of a singular plan to ensure the consistent implementation of treatment with regards to the management of Client #3 ' s maladaptive behaviors. Note: Client #2 also was under the care of two different treatment plans to manage her maladaptive behaviors; one for her home and one for her Day Program. Both plans target different maladaptive behaviors and provided staff with differing methodologies for managing those behaviors as well. 2. The facility ' s exterior doors are equipped with a very loud alarm/bell that rings whenever it was opened. This measure had been put in place to manage and prevent Client #4 from eloping.	W 159	W159 -2 The bell has been removed after an HRC and an IDT meeting was held.	2/14/07

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G162	A. BUILDING _____ B. WING _____	01/25/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES	4424 20TH STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159	Continued From page 2 The Qualified Mental Retardation Professional (QMRP) had failed to ensure that this restrictive measure was not presenting a problem for the other five residents in the home. [See W214 & W 264] 3. Client #2 had a speech and language skills acquisition program that was in place to improve her communication skills. The means by which the staff was to use the " low tech " device was not clear and it was also not clear the direction this program was to take since the client was failing to show progress. The Qualified Mental Retardation Professional (QMRP) failed to ensure this program had been re-assessed and revised as necessary. [See W257] 4. Client #1 had been assessed to function in the moderate level of mental retardation. Staff indicates that Client #1 was quite capable in communicating his needs, managing small tasks, and should be fully capable of taking part in taking his medications. Client #1 was not observed to take part preparing his medications during the evening med-pass and his records indicate that he was not a good candidate to take part as such. The Qualified Mental Retardation Professional (QMRP) failed to ensure the accurate assessment of this client ' s abilities to ensure he takes part in receiving his medications. [See W371] 5. During the Day Program observations, Clients #2 & #3 did not receive meals in the form and consistency as required by their respective Speech Pathologist, Nutritionists and Primary Care Physicians. The Qualified Mental Retardation Professional (QMRP) failed to ensure that these meals were prepared and served as	W 159	W159 -3 The Program for the 'low tech device' has been discontinued by the Speech and Language consultant. W159 -4 A Self Medication assessment was completed on this client on 2/1/07 and he will be started on a program as soon as approval is received from the Physician. See attached W159 -5 The QMRP will visit the day program at least monthly to monitor the meals. The day program food is catered by an outside caterer and the Physician's diet orders are sent to the caterer and the prescribed diet is sent to the day program.	2/14/07 2/20/07 2/20/07

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G162	A. BUILDING _____ B. WING _____	01/25/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES	4424 20TH STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159	Continued From page 3	W 159		
	ordered. [See W474]			
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN	W 214		
	The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs.			
	This STANDARD is not met as evidenced by: Based on observation, staff interview and record review the facility failed to assess the effects of an alarm bell for six of six clients residing in the facility.			
	The finding includes:			
	Several hours were spent observing clients at the residential facility between the dates of 1/23/2007 and 1/24/2007. During that time, a very loud bell would sound whenever the front door was opened . Staff was observed entering and exiting the facility throughout the survey across both days. During the evening observation on 1/23/2007, Client #3 was observed to " flinch " during her snack whenever the alarm would sound. Interview with staff revealed that the alarm was put in place and approved by the Human Rights Committee (HRC) to manage Client #4 ' s elopement. In addition, the Human Rights Committee (HRC) had not held a meeting at the home where the " bell " was approved. It was not clear why the alarm had been maintained after Client #4 was assigned a one-to-one staff to manage and prevent him from eloping. Nor was it clear why only the front door had the alarm and not the side door leading out of the dining room. Moreover, the side door was generally left unlocked and used by staff throughout the day and throughout the survey period. Incidentally,			2/14/07

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G162	A. BUILDING _____ B. WING _____	01/25/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES	4424 20TH STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 214	Continued From page 4 there were several instances where Client #4 ' s one-to-one staff was not in his immediate presence and was helping other staff around the home to manage other clients, which further complicates the need for maintaining the alarm. Record review failed to reveal that any of the clients residing in the home had been assessed against the need for keeping the alarm.	W 214		
W 257	483.440(f)(1)(iii) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. This STANDARD is not met as evidenced by: Based on observation staff interview and record review, the facility failed to ensure the revision of a client ' s Speech and Language program despite the client ' s lack of progress. The finding includes: Client #2 was observed attempting to communicate with staff and the survey team on the evening on 1/23/2007. Interview with the facility ' s Qualified Mental Retardation Professional (QMRP) revealed that Client #2 can actually communicate in complete sentences. Record review revealed Client #2 ' s Speech assessment dated 10/13/2005 recommended " the use of a ' low tech ' communication device to respond to query for personal data for 7 of 10 trials per session as measured by program documentation. " The Qualified Mental	W 257	W257 Refer to W159 -3	2/14/07

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G162	A. BUILDING _____ B. WING _____	01/25/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES	4424 20TH STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 257	Continued From page 5 Retardation Professional (QMRP) presented the data for this program dating back to 9/2006. Review of this data reflects that Client #2 had been performing at the " verbal prompt " level since 9/2006. It was also unclear how staff was to use the " low tech " device in helping Client #1 improve her communication skills. There was no evidence on file to substantiate that this client ' s programming was assessed and/or revised to meet her communication needs and the level of her current progress.	W 257		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure a committee review of a client ' s psychotropic medication regimen prior to implementation for two of three sampled clients. The finding includes: Observation revealed that both Client #2 and Client #3 are receiving a treatment regimen of psychotropic medication. Staff interview revealed that both clients ' received these medications to manage their intermittent explosive behaviors. There was no evidence on file to substantiate that these medications were reviewed by a specially constituted committee prior to implementation. [Reference W263]	W 262	W262 Medications were approved by the Human Rights Committee on 10/19/06, the BSP and the informed consent for medications was also completed. See attached	2/20/07

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G162	A. BUILDING _____ B. WING _____	01/25/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES	4424 20TH STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure consent of a legally appointment guardian prior to the implementation of treatment plans to manage maladaptive behaviors for two of three sampled clients. The findings include: 1. Observation of the evening medication administration on 1/23/2007 revealed that Client #2 received a 0.5mg tablet of Risperdal as part of her evening medication regimen. Staff interview revealed that this client receives this medication to manager her behavior. Record review revealed that this client was prescribed " Risperdal 0.5mg twice daily for intermittent explosive behavior " . There was no evidence on file to substantiate that this client ' s legally appointed guardian and/or decision maker had been made aware of the necessary risks of treatment prior to implementing this medication regimen to manager Client #2 ' s maladaptive behaviors. In addition, there is also no evidence that the specially constituted committee ensured the necessary consents required to include the provisions of the medication regimen into the client ' s behavior management plan(s). 2. Observation of the evening medication	W 263	W263 -1 This client had the Informed consent for Medications reviewed by the Human Rights Committee on 10/19/06 See attached	2/20/07

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G162	A. BUILDING _____ B. WING _____	01/25/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES	4424 20TH STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 263	Continued From page 7 administration on 1/23/2007 revealed that Client #3 received one 200mg tab of Tegretol, one 100 mg tab of Tegretol, and one 10mg capsule of Prozac as part of her evening medication regimen . Staff interview revealed that this client receives this medication to manager her behavior. Record review revealed that this client was prescribed " Tegretol 200mg 1 tab by mouth twice daily with 100mg [tab] to equal 300mg for intermittent explosive disorder " and " Prozac 10mg capsule 1 capsule by mouth every day for intermittent explosive disorder " . There was no evidence on file to substantiate that this client ' s legally appointed guardian and/or decision maker had been made aware of the necessary risks of treatment prior to implementing this medication regimen to manager Client #3 ' s maladaptive behaviors. In addition, there is also no evidence that the specially constituted committee ensured the necessary consents required to include the provisions of the medication regimen into the client ' s behavior management plan(s).	W 263	W263-2 Refer to W262, W263-1	2/14/07
W 264	483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review the facility ' s specially constituted	W 264		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G162	A. BUILDING _____ B. WING _____	01/25/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES	4424 20TH STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 264	Continued From page 8 committee failed to assess alternatives to placing alarms on the exterior doors of the facility prior implementation. The finding includes: During observation of the facility ' s activities and client management on the both 1/23/2007 and 1/ 24/2007 an alarm bell was heard each time the front door of the facility was opened. This occurred several times throughout the day on both days as staff entered and exited the facility. Staff interview revealed that the bell was put in place to manage the elopement problem they had with one of the clients and the Qualified Mental Retardation Professional (QMRP) was not aware of a lesser restrictive measure being pursued prior to implementing the alarm. Record review revealed that the specially constituted committee had not pursued a lesser restrictive measure prior to implementing and approving the use of the high pitched alarm on the exterior doors of the facility. Note: this alarm was loud enough to be heard from across the street whenever it goes off/ when the front door was opened. Inside the facility the noise factor was more poignant.	W 264	W264 Refer to W159 – 2	2/14/07
W 371	483.460(k)(4) DRUG ADMINISTRATION The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review revealed the facility failed to implement a	W 371		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G162	A. BUILDING _____ B. WING _____	01/25/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES	4424 20TH STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 371	Continued From page 9 self-medication program for one of three sampled clients. The finding includes: Client #1 was observed receiving his medications on the evening of 1/23/2007. The nurse was observed to punch his medications, and poured water for him to drink into a small cup. Client #1 was observed to take his medication and drink his water. Interview with the facility ' s Qualified Mental Retardation Professional (QMRP) revealed that Client #1 was able to independently take part in taking his medications. Record review revealed Client #1 ' s Self Medication Assessment dated 8/15/2006 recommended the following: 1. In " Section B (3) " of the self-medication assessment, Client #1 was identified as being an " an appropriate candidate for an oral self-medication program. " 2. In the " Overall recommendation " section of the self-medication assessment Client #1 was " not recommended for a self-medication program. " It was not clear what direction had been taken in providing a self-medication program for this client. It was also not clear if all pertinent parties were made aware of Client #1 ' s abilities with regards to his adaptive skills and being able to take part in taking his medications.	W 371	W371 Refer to W159 – 4	2/14/07
W 474	483.480(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client.	W 474		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G162	A. BUILDING _____ B. WING _____	01/25/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES	4424 20TH STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 474	Continued From page 10 This STANDARD is not met as evidenced by: Based on observation staff interview and record review, the facility failed to ensure that client ' s received meals in a form and consistency as ordered for two of three clients sampled. [Clients #2 & #3] The findings include: 1. Observations at Client #2 ' s Day Program revealed she received a meal of broccoli, mashed potatoes, sliced turkey breast, and a banana. Client #2 ' s broccoli was pureed, her mashed potatoes were presented soft, her turkey was cut into small bite sized pieces and the banana was presented whole. The Day Program staff was questioned about the reasoning for the differences in the consistency of the food items and the staff indicated they do not know why this client was receiving her meals that way. Record review revealed Client #2 ' s Speech assessment dated 10/13/2005 recommended a meal consistency of " chopped to bite sized food " . Client #2 ' s Physician Order Sheet (POS) dated 12/2006 also outlines this client was to receive her meals in a " bite sized foods " consistency. In addition, the standing order for the " bite sized " consistency on the Physician ' s order sheet had been in effect since 3/14/2002 and was different from the latest recommendation by the Speech pathologist as presented back in 10/2005 . There was no evidence on file to substantiate that the meals being served to this client at her Day Program are being served in the form and consistency outlined in her POS. Note: Client #2 was observed to peel her banana, and eat a third of it without any negative outcomes before her attending staff cut it into smaller pieces for her to	W 474	W474 Refer to W159 – 5	2/14/07

RTMENT OF HEALTH AND HUMAN SERVICES
ERS FOR MEDICARE & MEDICAID SERVICES

NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G162	A. BUILDING _____ B. WING _____	01/25/2007

PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
) HOMES	4424 20TH STREET, NE WASHINGTON, DC 20019

	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
4	Continued From page 11 eat. 2. Observations at Client #3 ' s Day Program revealed she received a meal of broccoli, mashed potatoes, sliced turkey breast, and a banana. Client #3 ' s broccoli was pureed, her turkey was of a chopped consistency, the mashed potatoes were presented soft, and her banana was presented whole. Client #3 was allowed to eat her meal but was not offered the banana. Record review revealed Client #3 ' s Nutrition assessment dated 1/5/2007 recommended a meal consistency of " finely chopped meats, bite sized other foods " . Client #3 ' s Physician Order Sheet (POS) dated 12/2006 verifies that this client was to receive her meals as "finely chopped meats, bite sized other foods" . There was no evidence on file to substantiate that the meals being served to this client at her Day Program are being served in the form and consistency outlined in her POS. Note: Client #3 was observed to peel her banana, and eat a third of it without any negative outcomes before her attending staff cut it into smaller pieces for her to eat.	W 474		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G162	A. BUILDING _____ B. WING _____	01/25/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES	4424 20TH STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 000	INITIAL COMMENTS A licensure survey was conducted from 1/23/ 2007 through 1/25/2007. Two males and four females with varying degrees of disabilities reside in the facility. Three of the six residents were randomly selected for the sample. The findings of the survey were based on observations at the group home, interviews with staff and residents, and the review of records including incident reports.	I 000		
I 044	3502.3 MEAL SERVICE / DINING AREAS All food and drink shall be clean, wholesome, free from spoilage, and properly prepared. This Statute is not met as evidenced by: Based on observation staff interview and record review, the facility failed to ensure that resident ' s received meals in a form and consistency as ordered for two of three residents sampled. [Residents #2 & #3] The finding includes: During the Day Program observations, Residents #2 & #3 did not receive meals in the form and consistency as required by their respective Speech Pathologist, Nutritionists and Primary Care Physicians. The Qualified Mental Retardation Professional (QMRP) failed to ensure that these meals were prepared and served as ordered. [Reference Federal Deficiency Report Citation W474 - §483.480(b)(2)(iii)]	I 044	I 044 Refer to W159 – 5	2/14/07
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive,	I 090		

Regulation Administration

.NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G162	A. BUILDING _____ B. WING _____	01/25/2007

: PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
) HOMES	4424 20TH STREET, NE WASHINGTON, DC 20019

	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
)0	Continued From page 1 and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and staff interview the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure the provisions of the section as outlined below: 1. The drawers in Resident #1 ' s night stand were broken. 2. Several glass panes in the door in Resident #1 ' s bedroom were missing. 3. Resident #2 ' s mattress was in poor condition; the bed springs could be felt through the mattress. 4. The sheets and pillow case on Resident #5 ' s bed were soiled of a brownish colored substance. 5. The toilet seat cover in Resident #5 ' s bedroom was unhinged from the seat. 6. The toilet bar handles in Resident #5 ' s bedroom were loose and could be moved from side to side. 7. The toilet bar handles in main hall were also loose and could be moved from side to side. 8. The cabinet area below the kitchen sink was water damaged and molded.	I 090	I 090 1. Drawers were repaired 2. Glass panes were replaced 3. Mattress was changed 4. Soiled sheets/ pillow case was discarded 5. Toilet seat was secured 6. & 7. Toilet bar handles were secured 8. Cabinet area was replaced	2/14/07
096	3504.7 HOUSEKEEPING No poisonous or hazardous agent shall be stored in a food preparation, storage or serving area. This Statute is not met as evidenced by: Based on observation the Group Home for Mentally Retarded Persons (GHMRP) failed to	I 096		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G162	A. BUILDING _____ B. WING _____	01/25/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES	4424 20TH STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 096	Continued From page 2 ensure the provisions of this section as outlined below: The finding includes: During the environmental inspection on 1/24/2007 cleaning agents were found being stored below the kitchen sink.	I 096	I 096 The cleaning agents were promptly removed and are presently locked The House Manager and the staff have been in serviced regarding this. See attached	2/14/07
I 421	3521.2 HABILITATION AND TRAINING Each GHMRP shall provide habilitation and training to residents in the most normalizing environment and the least restrictive circumstances. This Statute is not met as evidenced by: Based on observation, staff interview and record review the facility failed to assess the effects of an alarm bell for six of six Residents residing in the facility. The finding includes: The facility ' s exterior doors are equipped with a very loud alarm/bell that rings whenever it is opened. This measure has been put in place to manage an elopement problem for one of the six Resident ' s residing in the facility. The Qualified Mental Retardation Professional (QMRP) has failed to ensure that this restrictive measure is not presenting a problem for the other five residents in the home. [Reference Federal Deficiency Citations W214 - §483.440(c)(3)(iii) and W264 - § 483.440(f)(3)(iii)]	I 421	I 421 Refer to W159 – 2	2/14/07
I 426	3521.5(c) HABILITATION AND TRAINING Each GHMRP shall make modifications to the	I 426		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G162	A. BUILDING _____ B. WING _____	01/25/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES	4424 20TH STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 426	Continued From page 3 resident ' s program at least every six (6) months or when the client: (c) Is failing to progress toward identified objectives after reasonable efforts have been made; This Statute is not met as evidenced by: Based on observation staff interview and record review, the facility failed to ensure the revision of a resident ' s Speech and Language program despite the resident ' s lack of progress. The finding includes: Resident #2 has a speech and language skills acquisition program that is in place to improve her communication skills. The means by which the staff is to use the " low tech " device is not clear and it is also not clear the direction this program is to take since the resident is failing to show progress. The Qualified Mental Retardation Professional (QMRP) failed to ensure this program has been re-assessed and revised as necessary. [Reference Federal Deficiency Report Citation W 257 - §483.440(f)(1)(iii)]	I 426	I 426 Refer to W159 -3	2/14/07